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Abstract

Purpose: This review and theoretical analysis paper brings together literatures of place, mobility, refugees, and mental health to problematize the ways in which social support is practised on the ground and to re-think its possibilities.

Approach: The paper draws on an interdisciplinary understanding of social support that focuses on the social networks, significant and intimate relationships which mitigate negative mental health and well-being outcomes. We explore the dialectic relationship between place and mobility in refugee experiences of social support.

Findings: We argue that, in a Euro-American context, practices of social support have historically been predicated on the idea of people-in-place. The figure of the refugee challenges the notion of a *settled* person in need of support and suggests that people are both in place and in motion at the same time. Conversely, attending to refugees' biographies, lived experiences, and everyday lives suggests that places and encounters of social support are varied and go beyond institutional spaces.

Implications: We explore this dialectic of personhood as both in-place and in-motion and its implications for the theorisation, research and design of systems of social support for refugees.

Keywords: refugees, mental health, social support, place, mobility.

Word count: 9,216

Introduction

Mental health and psychosocial wellbeing are among the greatest challenges facing global society today and it seems more important than ever to examine the assumptions underlying efforts to support those who are psychologically vulnerable. In this paper we focus on issues of mental health and psychosocial wellbeing as these relate to refugee populations with a specific focus on the case of migration to Europe and the UK in particular (although, we also make reference to examples from other locations in Europe). We draw our understanding of the term social support from literature in social psychiatry and social and community psychology (Gottlieb, 1985; Rappaport, 1981; Saranson and Saranson, 2009). The contemporary usage of the term social support tends to refer to a broad category of professionals and professional responses to experiences of mental ill-health and the promotion of well-being, and such responses might be provided by one professional group (e.g. social workers, medics, psychiatrists) or may involve professionals working together in interdisciplinary groups. The organisation and philosophical underpinnings of mental health care have undergone what may be seen as a fundamental paradigm change in the past five decades, moving from a view that those experiencing mental health problems should be removed from the community and placed in institutional care, to one in which services support a model of care in the community (Bornat, 1997; Bushfield, 1997; Medeiros, 2008; Novella, 2010; Novella, 2008; Scull, 1984; Walker, 1997). This shift of perspective has been accompanied by large scale organisational change in which services are in the main delivered through community mental health teams (CMHT). Interdisciplinary CMHTs are ubiquitous and their work is embedded in the wider institutional contexts of local communities where they are encouraged to forge supportive partnerships with GP surgeries, hospitals, schools, housing services, police, local employers and workplaces. Current initiatives such as social prescribing, engagement with nature and open spaces, mindfulness and therapeutic interventions such as open dialogue, are underpinned by a view of the person with a mental health problem as situated within a community and the community in turn as a latent resource that may be mobilised for healing and recovery.

By contrast the situations faced by forced migrants may combine dynamics of sudden and

ongoing displacement with the presence of significant levels of mental health problems. Studies from the UK and systematic reviews of studies across European countries suggest higher rates of depression and anxiety among asylum seekers and refugees compared to the national population or other migrant categories (Raphaely and O'Moore 2010). A range of research across the health and social sciences point towards the physical and mental impact of conflict and war in countries of origin as well as in destination countries (Attanayake et al, 2009; Fazel, Wheeler and Danesh, 2005; Fazel et al, 2012; Kirmayer et al, 2011; Murthy and Lakshminarayana, 2006), including the trauma associated with migration and settlement processes (Canetti et al, 2010; Johnson and Thompson, 2008). Issues that pertain to social identity and community life, such as isolation, loss of social status, poverty and insecure legal immigration status, and the impact of government policies such as detention and dispersal in the receiving society (Silove, Steel and Watters, 2000), also contribute to the vulnerabilities experienced by refugee populations.

In this paper, we are particularly concerned with thinking about the responses to these vulnerabilities which are addressed through a range of infrastructures and practices of social support. In particular, we explore the assumptions underpinning the provision of social support for refugees. For example, in Europe, a member of the general population may seek out information and support for their mental wellbeing online or through primary healthcare services (Barbato et al., 2016). Depending on the country where support is sought, severity of distress, initial assessment, as well as material resources, such a person is likely to be offered support through various interventions including medication and/or access to a form of a talking therapy, of varying degrees of duration (Sadeniemi et al, 2018). In more severe cases, assessments may lead someone to access specialist, secondary care services in the community or health care facilities (Sadeniemi et al, 2018; see also Naylor, Taggart and Charles, 2017). Face-to-face mental health support, where possible to access, is likely to take place in a physical location (a building, an office, a room, person's home) that ideally offers a quiet space and some privacy for conversation or other therapeutic activities. For those not able to access support in this more conventional way, online, Skype and telephone consultations might be offered (Barak and Grohol, 2011; Newhouse, Lupiáñez-Villanueva, Codagnone and Atherton, 2015).

Yet, whether social support is provided face-to-face or virtually, we argue that existing models of state provision rest on assumptions of 'settledness' (e.g. a fixed location, a post code), of a person-in-place, which are challenged by experiences of being a refugee. Such continued

assumptions of settledness coincide with the increasing evidence of the usefulness of mobile health clinics (Yu et al., 2017) suggesting that practices that attempt to bring place and mobility together are unfolding on the ground. In a historical moment of mass migration, the locus of support takes on a new meaning – one tackled in this article – and the need to experiment with forms of social support that engage dialectically with mobility and stasis comes to the fore.

In this article, the experience of being a ‘refugee’ is approached as an experience in flux at a social, psychological, cultural, and geographic level. In particular, using a biographical framing of refugee experiences we explore the dialectic relationship between place and mobility in refugees’ access to social support. We argue that practices of social support have historically been emplaced in buildings and local communities. The acceleration of migration in recent years challenges such emplacement and calls for a closer examination of mobility in the provision of social support. Furthermore, ethnographic studies of refugees’ everyday lived experiences, as well as other quantitative and qualitative evidence (Posselt, Eaton, Ferguson, Keegan and Procter, 2018) suggest that social support also emerges beyond institutional boundaries, and these sources of support and enablers of well-being need to be acknowledged, at the very least not impeded, further researched and supported. Such sources of everyday social support can form the basis for re-thinking and innovating on existing provision with good practice cutting across both innovative initiatives offered by a wide range of NGOs as well as informal humanitarian support networks (Teloni, 2011; Teloni and Adam, 2018; Watters and Ingleby, 2004; Watters 2007).

The paper is a review and theoretical analysis of selective literature on refugee mental health, and services and projects, regular or ephemeral and/or current or past, addressing refugee mental health. Our analysis is then organized into five sections. Section one focuses on refugee lives specifically on the ‘journey’ metaphor that is prevalent in framing our understanding of refugee lives and suggestions are made for a more biographical understanding of refugee lives. Section two explores meanings of social support in particular as these relate to mental health. Sections three and four of the paper address issues of place and mobility in the delivery of social support for refugees, respectively. Section five reviews the ethnographic literature on refugee everyday experiences of social support and reported enablers of psychosocial and cultural well-being. We conclude by suggesting ways in which both refugee biographies and everyday lived experiences might contribute to the re-visioning of existing practices of social support.

Refugee lives: out of place

The metaphor of ‘journey’ has long framed the literature on the refugee passage from country of origin to place(s) of eventual settlement. This point-to-point conceptualization of the refugee journey (Ager, 1993), or so-called ‘refugee curve’, has also long been critiqued (Eastmond, 1998), and the contingency, non-linearity and circularity of such ‘journeys’, the ‘enigmas of arrival’ (Watters, 2008), and the impact of local legislation and policy contexts, are increasingly recognized. Hagen-Zanker and Mallett (2016), having attempted to sketch out a ‘typical’ refugee journey conclude that such journeys are heterogeneous affairs. Journeys and their outcomes are contingent, often non-linear and rarely straightforward: points of departure are hard to define, plans mutate, and destinations change, journeys can be fast and slow, expensive, harassed, and frustrated; and violence and death during such journeys is increasingly becoming normalized.

Intervening into the framing metaphor of the journey, BenEzer and Zetter (2014) have argued that there is a gap in refugee studies with regards to understanding of the ‘passage’ and an underappreciation for the significance of such journeys, beyond a transition between places. In their article, they sketch out the different considerations that might go into thinking about a ‘refugee journey’, understood as an event or activity, including its temporal characteristics (beginnings, durations, ends) and experience, its drivers, destinations and deviations, its process and contents (e.g. mode of travel) and of course, the biographies of the ‘wayfarers’ themselves.

Hagen-Zanker and Mallett’s (2016) research, together with that of Nardone and Correa-Velez (2016), suggests that a more narrative, and we would add biographical, understanding of ‘refugee journeys’ is necessary. Their argument is made on the basis that, for many, ‘journeys’ start long before actual departure from their country of origin, when the idea of migration takes shape, and often do not conclude by the time resettlement has formally been achieved. Immigration control and welfare ‘trajectories’, especially for children, contribute to protracting the refugee journey in complicated and tense ways (Watters, 2008). As such, it might be more fruitful, as Kaytaz (2016) suggests, that journeys be understood as ‘a form of narrative constructed by migrants encompassing long periods of immobility punctuated by shorter instances of travel’ (p. 285).

In this sense, focusing on lives, and their narration, instead of journeys alone, allows for a broader understanding of refugee experiences at times of mobility as well as stasis. The so-called 'journey' is only one part of a much larger biography and migration history of the individual, family or group. The idea of unified, coherent and unchanging self, a residue of the enlightenment imagination, is not only challenged by cross cultural understanding of what constitutes a person, but is also increasingly challenged in the contemporary historical moment of rapid and unexpected social change. As Michael Jackson points out 'everyone – not only displaced people and strangers – struggles with transitions, changes, estrangements, losses' (n.p.; see also Jackson, 2009).

Contemporary perspectives on biography (Plummer, 2001; Bond Stockton, 2009; Lahad, 2018) stress that lives are often fragmented and messy, full of ambiguities, contradictions and tensions that are not always easily resolved. Contingency and chance in the shaping of the life course (Elder, Modell and Parke, 1993; Jackson, 2013) is especially underappreciated, and in the case of refugee experiences an important framing for understanding biographies. For example, the change of national policies of migration in response to public opinion in a number of European countries since the summer of 2015, impacted on experiences of border crossings and therefore, experiences of both mobility and stasis as many ended up staying far longer than intended in border camps.

As well as drawing attention to the fragmented, messy and contingent nature of lives, a biographical approach to understanding refugee experiences allows for a more nuanced understanding of the interplay between vulnerability and resilience both in place and in motion (Nardone and Correa-Velez, 2016; Morrice, 2011; Sampson, et al, 2016). As Watters (2008) has argued refugees are not just the victims of globalization and their agency, in even the most difficult of circumstances, needs to be accounted for (cf. Morrice, 2011; Williams, 2006). The biographical approach, we contend, is an approach that can respond to this challenge (of accounting for agency under extreme contexts, situations and life events) because it allows us to locate our gaze on everyday lives and lived experiences and to explore the ways in which people react, respond to, and engage with adversity. It is also an approach that allows for cultural specificity of how lives are lived by different peoples, and significant rites of passage that mark various life transitions, that make lives meaningful and which the refugee experience disrupts (Watters, 2007). This is important in the context of the Global Mental Health movement where

interventions are often underpinned by developmental models of a person (e.g. ‘the life course’) and understanding of ‘trauma’ that are Western-centric (Stewart, Anderson, Beiser et al, 2008; Summerfield, 1999; Watters 2017) and which fashion life trajectories as overly linear. Such linearity is challenged by ethnographies of the ‘good life’ in the Global South (Jackson, 2013), as well as a much wider body of literature in health and illness which explores the ethics of living with chronic illness and biographical disruptions (Irving, 2017; Mattingly, 2010) and which argues for the creativity involved in making a life liveable. What these literatures importantly emphasize are the ways in which people may engage in processes of mobilisation of resources in order to make their lives liveable in the face of disruption (Locock and Ziebland, 2009). With this framing in mind we next turn to the meanings and practices of social support found in the literature.

Exploring the meanings of social support

Our understanding of social support draws on Gottlieb’s seminal work (1985) in which social support is understood as a key mediator of (mental) health and well-being particularly in the context of stressful life events. Social support is understood as the extent to which a person is integrated and participates in society (e.g. institutions, voluntary associations and the informal life of their community), as well as the extent to which a person has more intimate social network (e.g. their friends, colleagues, significant others and those who regularly provide them with advice, material and symbolic assistance, companionship, emotional nurturance etc). Social support is also understood as a person’s most intimate relationships (e.g. a girl/boyfriend or spouse in which the person can confide in). Throughout the 1990s and into the 2000s research and practice in social support burgeoned in community psychology, critical social psychology and community based social work (Saranson and Saranson 2009; Rappaport, 1981). There is a continued interest in policy, practice and research in the role that social support plays in mitigating adverse mental health and well-being outcomes (Maulik, Eaton and Bradshaw, 2010; Smyth, Siriwardhana, Hotopf, and Hatch, 2015). In the case of migrants and refugees, the concept of social networks (Warner 2007) has been central in shaping social support. Social networks are commonly perceived to be based around shared experiences, such as living in the same fixed location or sharing a national identity (Curtis 2010). Such relationships, as well as more proximal ones, have long been recognised as fundamental to mental health and wellbeing

as they are thought to mitigate experiences of exclusion and social isolation of those with chronic mental illness, particularly during acute periods (Berkman 1995; Cattell 2004; Lester 2013).

A contemporary and increasingly popular way in which social support, as defined above, is being realised is through the paradigm of ‘social prescribing’, a form of ‘holistic’ medicine currently used to manage a range of diverse illnesses, including anxiety, depression and schizophrenia (Watters, 2020). The social paradigm emphasises the sociocultural origins of mental processes and of mental illness (Fakhoury and Priebe, 2007) and wellbeing is understood to be relational and therefore best safeguarded through some form of collective or relational processes (Stickley, 2008). Programmes drawing on such an understanding of mental well-being aim to (re)integrate individuals by means of active participation in society and by strengthening interpersonal relations, goal-directed behaviour and everyday routine activities (Pilgrim, 2009). Treatments can involve encouragement to engage in work and building effective relationships. Such treatments also commonly focus on the (re)generation of relationships which are assumed to have faltered after an individual has suffered a prolonged period of mental illness. Services aligned with this approach advocate personal transformation and change within the public, relational context of the community. Services in the UK that emphasise social cures do so alongside standard pharmacological treatments to reduce the prevalence of such experiences.

At present, the outcomes for social cure approaches to mental health support in the literature are mixed (Bickerdike, Booth, Wilson et al, 2017). The approach has been criticized for its, sometimes, deleterious effect on patients, and service provider assumptions about what it means to be ‘sick’ (and to ‘recover’), that do not always correspond with the experiences of service users (Whitley, 2014). The consequence can be that clients’ sense of competency, agency and selfhood are undermined (Estroff, 1981). Such undermining is often the result of a failure to acknowledge the limitations that broader social trends in which mental health recovery takes place, such as austerity policies and the marketisation of public services (Baird, Cream and Weeks, 2018). Additionally, the original emphasis that social support places on agency, participation and collaboration between those providing support and those receiving it, something which requires a more politicised view of mental health, is often lost (Campbell and Cornish, 2014). Finally, contemporary social support often misses the messier, affective and dynamic dimensions of giving, receiving, practising and supporting efforts that (may) improve lives (see Alber and Drotbohm 2015; Cabot, 2013; Nolas, 2014; Schlecker and Fleisher, 2013),

as well as the more spontaneous and informal ways in which a feeling of being supported might come about (Kay 2011). For instance, Wessendorf (2018) found that despite encouraging refugees/migrants to integrate and forge social ties, the supportive connections that migrants and refugees themselves make are much more random in practice. We return to this theme in the last section of the paper; for now, we turn our attention to place in mental health social support.

Place and mental health social support

Many contemporary enactments of social support (gardening, social clubs etc) are also predicated on settledness. As such, in the case of refugee populations, it is not always possible to benefit from institutional forms of social support, such as ‘social prescribing’. There are historical reasons for the emphasis on settledness. In Britain, for example, social support initiatives have long encouraged people to remain fixed in certain locations in order to be eligible for support. For example, the Elizabethan poor law meant that the ‘settled’ poor, who remained in local parishes, were eligible for outdoor relief in their home or indoor relief in the alms houses. Similarly, place has also been central to conceptions of mental health provision. Curtis (2010, p. 191) argues that from the 18th century onwards in most Western countries the notion of the asylum as a ‘refuge’ or ‘fortress’, separating the mad from their communities, prevailed. Therapeutic spaces and hospitals that emerges much later (e.g. mental health in-patient units), had the dual role of being comfortable, protective and homely on the one hand, as well as managing and controlling on the other (Curtis et al., 2007).

In order to think about place and social support in the case of refugees and asylum seekers a broad distinction may be drawn between those caught in protracted refugee situations (PRS) and those who are seeking asylum. Millions in PRS live in camps, the origins of which can date from as far back as the late 1940s. Recently referred to as ‘waiting zones outside society’, camps are spatio-temporal locations in which ‘time is expanded, but place is compressed’ (Bandak and Janeja, 2018, p.6- 7) and wherein refugees are often referred to as being ‘warehoused’ with little opportunities for them to leave and move elsewhere. Despite the durability of these camps, refugees often cling to a hope of return to their places of origin and seek to maintain intergenerational consciousness of a sense of home and right to return.

While camps are associated with protracted refugee situations, reception centres and dispersal are associated with the experiences of asylum seekers. Asylum seekers are viewed as

spontaneous, unplanned arrivals and the buildings in which they are housed are often makeshift, adapted for use from former schools or army barracks. The duration of stay is time limited and subject to abrupt changes including movement to other parts of the country through dispersal programmes and detention pending deportation. The procedures undergone by asylum seekers have themselves been linked to the emergence of mental health problems and the exacerbation of conditions such as PTSD (Silove, Steel and Watters, 2000). Reception centres are often highly controlled environments, with some operating strict curfews and surveillance including severe restrictions on what asylum seekers can bring into centres and how they can shape their places of dwelling and therefore limited opportunities for exercising agency (Watters and Hossain, 2008; for a discussion on controlled environments and agency see also Korac, 2003).

Once beyond ‘the camp’, the spaces in which refugees receive support are often embedded within other ‘processing’ systems, such as immigration control and welfare provision. Within these contexts, processes of ‘strategic categorization’ operate, in which health and mental health problems may be identified strategically in the context of supporting asylum cases (Watters, 2001). Evidence of PTSD presented in countries in which asylum seekers are seeking protection may be significant in demonstrating experience of persecution and torture in home countries. The Refugee Council and key NGOs such as Freedom from Torture may identify the symptoms experienced by asylum seekers as part of an evidential base in reports to the Home Office. In these cases, mental health support for refugees may be seen as located with a bureaucracy of gaining asylum and offer a vital component in asylum claims.

Within such a context it is important to consider the ‘entitlement and access’ gap that shapes any access to mental health support (Watters, 2011). For example, in European league tables on asylum seeker treatment the focus may simply be on what asylum seekers are entitled to rather than the services they can actually receive. There are often considerable gaps between law and policy on the one hand and the experience of getting necessary services on the other (Chase and Rousseau 2017; Watters *ibid*). Countries that may look impressive at the level of entitlement may, in practice, offer little access in terms of support for asylum seekers. More likely, the entanglement of immigration control and welfare provision generate regimes of surveillance and control that many migrants find oppressive.

Furthermore, as noted above, the reception of asylum seekers is often accompanied by heavy bureaucratization (curfews, constraints on movement, and activity) creating oppressive

environments and undermining sense of individual agency and control over one's life experiences and circumstances which is thought to be key for mental *health*. In social work and allied professional services for refugees, especially those operating 'in extremis', there are attempts to acknowledge service users' agency through the adoption of asset-based approaches to social support (SCIE, 2017) and the strengths perspective (SCIE, 2015) is finding a new lease of life, too. Recent interventions into the discourses of Global Mental Health have also called for social support policies and providers to pay greater attention to the impacts of context, culture and local survival strategies in people's responses to adversity and mental *ill*-health (Campbell and Burgess, 2012).

Upon arrival in a host country and in line with the philosophy that social support is created by and within, place-based social networks, refugees are 'encouraged' to stay in places and forge ties. Resettlement programs emphasise the need for "strong group-based social support as well as a focus on practical needs such as acquiring and maintaining employment, language and literacy training, and access to care" (Mitschke et al., 2017). Refugees are also encouraged to maintain relationships with places, such as "connections with institutions, including local and government services" (Alencar 2017, p. 4). In the case of people with mental health needs and a history of migration, Bekkum and colleagues state that there is need for "continuity and stability in the life of the [psychiatric] patient" (2010; 119) arguing that this involves a process of 're-embedding' the client in "secure spaces" - i.e. systems which replicate the familial network (ibid; 121). For refugees/migrants, this involves building 'safety nets'; social networks and social support around the individual (even if these are temporary) in a process of 'wrapping' which is "healthy and stabilising" (ibid;123). As such, in contemporary policies and practices of refugee social support, there continues to be a strong focus on belonging, place-making and re-territorialisation for migrant and refugee health and well-being. However, such a focus, as Watters (2008) argues, misses that experience of refuge lives which spread across numerous geographical locations. As such, traditional institutional sites, such as schools and hospitals, that are typically seen as desirable places to introduce mental health programmes, are of little utility when children and young people are on the move (ibid). We turn to the issue of mobility next.

Mobility and mental health social support

As with trends for supporting the general population experiencing mental health difficulties so too have practices of refugee social support embraced the digital. Mobile health apps delivering therapies and other forms of online help are considered to be cheap, accessible ways to receive quick emotional and practical support to refugees who are on the move or temporarily located (Ben-Zeev, 2014; Kay et al., 2011). Examples include *ALMHAR*; described as a ‘support for self-help’, the app is available in Farsi, English or Arabic and consists of a series of descriptions of what it describes as ‘common emotional problems’ and simple exercises designed to alleviate distress, which can be completed alone’. There is also *Karim*, an artificial intelligence program (chatbot) which provides psychological support to refugees by producing personalised text message conversations in Arabic in response to user’s texts. *Tess* is a similar programme in development, which includes a function that detects when a user is in ‘severe’ distress – for example because they may make reference to suicide or self-harm – and if they are, it connects to a psychologist to initiate a counselling session. There are also telephone lines where volunteers provide counselling outside of normal service hours, in languages such as Arabic, French, English, German. There are multiple advantages to these kinds of technologies, for example, that they can be used in a person’s own time and space, and that they can be engaged with as and when needed. They also enable people, who mistrust authorities and who avoid services or the police, some independence and access to information they need through their own smartphones.

However, it is recognised that alone, these types of support are not enough - they are usually intended to fill a gap. The big problem, as Olff (2015) identifies is that a lot of the apps lose their funding or are not updated. App and online support that is amendable to mobility is also vulnerable to access issues such as faulty connections, specialised up-to-date technology, chargers and electricity, as well as potential privacy issues and even in some cases, government surveillance (Wall et al. 2017). Furthermore, it has been pointed out that these kinds of online support systems lack evaluation, particularly when used in situations where there are no other available alternatives (Wessells, 2008). For example, Wall and colleagues’ (2017) study of social media technology use documented the phenomena of ‘information precarity’ - how misleading, unreliable and out of date information led to rumours and stereotyping, causing anxiety, confusion and stress among Syrian refugees.

Outreach has also been a response to the ‘out of placeness’ of refugee experiences – particularly in relation to mental health services. Since the 1980s, such services have been developed across several European countries in response to calls by mental health service users, and professionals, and paradigm shifts in mental health care from the institution to the community. When and where outreach has been used adult mental health service users have reported greater satisfaction in services (Killaspy, 2006; Van Citters & Bartels, 2004). For example, Maglajlic and colleagues (1993) in Zagreb developed an outreach programme in order to respond to social isolation faced by internally displaced people and to identify people who were housed with their family members and as such, typically ‘out of sight’ (and ‘off site’) from traditional services. The programme involved a daily drop in service, where both women and children (as the most common IDPs from Croatia and refugees from Bosnia) gathered and used as a communal space. Women used it to catch up, watch soaps, knit, drink coffee, hang out, while kids used it to play with each other. Specialists (GPs, gynaecologists, psychotherapists) offered their services in more private spaces within the drop in. Activities were organised for children to occupy themselves while their mothers accessed specialist support services. In recent years, however, especially in the UK, outreach efforts have been complicated through the introduction of community treatment orders, reinforcing the punitive and controlling nature of some mental health support. For refugees, outreach services have been developed for targeted interventions with young people, as a part of a suite of community engagement and support initiatives (for example, Project SHIFA in Boston, Ellis et al., 2011) or within schools (O’Shea et al., 2000).

Everyday life and mental health social support

In this final section, we return to refugee everyday lives to further explore the ways in which social support manifests there. In other words, as refugees are in motion (moving from place to place, possibly not entirely settled) what do we know about their practices of feeling supported and their use of places for support, which in turn we know contributes to agency, mental health and well-being? Much of the literature on refugees focus on movement as loss and pays little attention to the agency and meaning that refugees themselves bring to their everyday lives. While the circumstances that lead to decisions to leave a home and a country may not be of someone’s choosing, the decision to move elsewhere is also a testament to aspiration, to a vision

of a future and the hope of a better life. In this sense ‘displacement’ is also ‘to assure oneself of a distance by which to look askance and create anew’ (Rapport, 2007, p. 124), it is, as such, a practice of becoming.

Ethnographic studies of those suffering from mental ill-health and refugee experiences provide some evidence of where these practices of becoming might take place, and the importance of migratory networks and transnational communities. For example, Williams’ research in Thanet, south east England, showed that “help-seeking behaviour and life strategies were significantly influenced by the social networks of individuals, even when those networks were transnational and when individuals had little or no apparent local support” (2006, p. 866; see also Varvantakis, Dragonas, Askouni and Nolas, 2019). As Lelièvre and Marshall argue (2015, p.435) ‘ethnographers of transnational migration have demonstrated that even the most disenfranchised subjects creatively network, wire money, and otherwise create ‘spaces of connectivity’. In a similar vein, Papadopoulos and Tsianos (2014, p.190) describe the undulating relationships and practices of social support of migration as a ‘mobile commons’. Digital spaces are increasingly becoming important spaces for ‘hanging out’. Online forums, Facebook groups, and informal chat spaces are places where many people seek out emotional support and forge ‘webs of belonging’ (Berg, 2017, p. 303; see also Wellman, 2001; Bar-Lev, 2008; Lowe et al. 2009; Pfeil, 2009). Those leading mobile lives, including refugees, often use digital technologies and social media to make their own communities and ‘places’, both online or in conjunction with physical locations (Khvorostianov et al., 2012). They also use online spaces to access material support such as collated information about ‘where to cross’. As Diminescu argues: “Today's migrants are the actors of a culture of bonds, which they themselves have founded and which they maintain even as they move about...It is more and more common for migrants to maintain remote relations typical of relations of proximity and to activate them on a daily basis. The paradigmatic figure of the uprooted migrant is yielding to another figure: the connected migrant” (2008, 565).

Similarly, Komito argues that physical location is of much less relevance to migrants nowadays in terms of how they keep in touch with support networks. His study of Polish and Filipino non-nationals in Ireland revealed that migrants rely on social networking sites and communication technologies for the maintenance of personal networks but also to connect with communities of ‘affinity’ (support groups where people share their experiences) (Komito, 2011;

1082). Like others, migrants are constantly engaging in ‘purposeful communicative acts’ with kin and friends from their country of origin as well as ‘low intensity participation’ online which increases their sense of connection with (geographically) distant others (ibid). Alencar’s study of Syrian, Eritrean and Afghan refugees revealed that using social media to contact and stay updated with friends’ and families’ life helped them feel “satisfied and receive the emotional support they need in order to address the challenges living in a new country” (Alencar, 2017, 10). However, the study also pointed to dissatisfaction among refugees with social media - the “disadvantages of ‘excessive social networking’” (ibid; 9). Some participants found it problematic to spend long amounts of time on social media and found it distracted them from their initial surroundings.

As Papadopoulos and Tsianos argue, people on the move “create a world of knowledge, of information, of tricks for survival, of mutual care, of social relations, of services exchange, of solidarity and sociability that can be shared, used and where people contribute to sustain and expand it” (2014, p. 48). These mobile commons are necessarily temporary and precarious spaces, below the radar of the authorities, but they bring about new socialities and solidarities. In this sense, the everyday lives of refugees and experiences of migration can be understood in terms of what Al-Mohammad and Peluso (2012) call ‘ethics of the rough ground’. Accordingly, such ethics are messy and entangled, and pain, suffering, joy and the ennui rest alongside issues of care and concern. Time of crisis can also help people to develop coping strategies that enable them to develop elusive resources: ‘these strategies may include relations of trust and care, economies of affect, networks of reciprocity encompassing both tangible and intangible resources, and material and emotional transfers that are supported by moral obligations’ (Narotzky and Besnier, 2014, p. S6).

Understanding refugee biographies in everyday life circumstances allows for the re-instatement of agency, on the part of the refugee, who rather than a passive victim can once again be thought about as human actors with beliefs, desires and hopes, as well as a pasts, presents, and futures, who are resilient and resourceful in scaffolding social support for themselves and others around them, even if they may not yet reflect on their own practices as such.

Conclusion

In this paper, we have provided a critical review of the issues raised for practices of social support by the figure of the refugee, and in particular the dialectic tension between place and mobility that often characterises refugee lives in particular. The figure of the refugee challenges the notion of a *settled* person and suggests that people are both in place and in motion at the same time. Approaching these tensions from a biographical perspective that foregrounds agency, we have surfaced assumptions, possibilities and limitations in emplaced and mobile practices of social support. We highlighted key metaphors that shape our thinking about refugees ('journeys') and social support ('social networks', online and face-to-face).

The aim of the paper has been to open up ways of thinking about social support that go beyond established metaphors and which foreground refugee biographies, agency, interdependence, and the serendipity of everyday life. In this sense, the paper joins current efforts to rethink social support, its location, timings and practices that could be perceived to be fairly asymmetrical (i.e. charity worker, charity receiver) (Schlecker, 2013; Schlecker and Fleisher, 2013). Support can manifest itself in many ways, including specific practices or 'acts' (Kleinman, 2015) as well as the less tangible or material aspects such as emotions, attitudes and feelings. The analysis presented, in which place and mobility, off-line and online support appear entangled in complicated ways in refugee lives, would further support existing calls to 'complicate' approaches to social support (Nolas, Sanders-McDonagh and Neville, 2018) and to hone attention to the spaces in-between 'caring for' and 'caring about', 'care giver' and 'care receiver', 'affect' and 'efficiency' (Tronto 2013; see also McKie et al, 2002; Watson et al, 2004). Importantly, the support that emerge in such liminal spaces are not confined to particular rooms or times of the day. Time and space are intertwined and needs and support are perpetually and dynamically re-negotiated. In this respect, relationships both in conventional locations of social support as well as beyond them are important to explore.

In highlighting the role of place as central to the provision of social support, both in the general population as well as in the case of refugees, we are not dismissing its role of place as an appropriate location for the delivery of social support or as a mediator of mental health and well-being, or the possibilities of being supported through mobile technologies and outreach practices. A number of studies point to the importance of the physical environment on mental health and well-being (see for example Gesler 1992's classic work on 'therapeutic landscapes' and more recently Brewster's (2014) study of public libraries as 'recession sanctuaries'). The point is

rather, to highlight the centrality and universality of place in the provision of social support in order to start to think differently about the possibilities of providing such support in different times, locations and catering to the needs of populations on the move.

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